

## Section IV. Mental & Behavioral Disorders

# Depression

# 22

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### OVERVIEW & DEFINITIONS

Depression is common, disabling, and often unrecognized or inadequately treated in general medical practice. This chapter focuses on the diagnosis and management of major depression. Other mood disorders are briefly discussed, including chronic depression (dysthymia), minor depression (adjustment disorder with depressed mood and depression not otherwise specified [NOS]), depression secondary to general medical conditions, and bipolar disorder (Table 22-1).

**Major depression (MD)**, the most severe form of depression, is associated with considerable disability, morbidity, and mortality. Epidemiologic studies demonstrate that depression is associated with as much, and often more, physical and social disability as other chronic illnesses, such as diabetes, arthritis, hypertension, and coronary artery disease. The increased risk of death seen in patients with depression is only partially attributable to the increased risk of suicide. Recent studies indicate a 59% increase in mortality among nursing home patients with major depression and a threefold increased risk of mortality among postmyocardial infarction patients with comorbid major depression.

**Chronic depression, or dysthymia** is a milder but chronic form of depressive illness that is associated with significant disability. Dysthymia is diagnosed when depressed mood and at least two other symptoms of depression are present "most days" during the previous 2 years.

**Minor depression**, which causes functional impairment but does not meet the criteria for major depression, includes adjustment disorder with depressed mood and depressive disorder not otherwise specified (NOS). **Adjustment disorder with depressed mood**

results from an identifiable stressor, such as divorce or job loss. It presents with a level of impairment greater than is expected for most individuals and can be diagnosed within the first 6 months after a stressor has occurred. A "normal" reaction to a distressing life event should not be diagnosed as an adjustment disorder. When a stressor precipitates a depressive syndrome that meets the severity criteria for major depression, the diagnosis of major depression is made. **Depressive disorder NOS** is a condition that lasts longer than 6 months after a precipitating stressor. Depression NOS is also used to describe mixed states of anxiety-depression that do not meet criteria for other anxiety or depressive diagnoses.

**Mood disorders due to a general medical condition (or substance)** refers to a psychiatric syndrome judged to result from the direct physiologic consequence of a general medical condition (eg, hypothyroidism), substance use (eg, amphetamine withdrawal), or medication (eg, reserpine). Treatment focuses on resolution of the underlying general medical problem or withdrawal of the offending medication, although specific psychiatric treatment may also be required.

**Bipolar disorder** (also known as "manic-depressive" illness) is a common and severe mental illness that occurs in about 1% of the population and carries a strong genetic vulnerability. Patients with presumptive diagnoses of depression should always be screened for bipolar disorder.

Table 22-1. Mood disorders.

1. Major depression
2. Chronic depression (dysthymia)
3. Minor depression
  - a. Adjustment disorder with depressed mood
  - b. Depression NOS (not otherwise specified)
4. Depression secondary to a general medical condition
5. Bipolar disorder

## EPIDEMIOLOGY

Epidemiologic studies demonstrate a lifetime prevalence of major depression in 7–12% of men and 20–25% of women. The point prevalence of major depression in a community sample is 2.3–3.2% for men and 4.5–9.3% for women. Reasons for these gender differences have not been fully elucidated, but both biological and sociocultural factors are involved. Numerous studies report a 5–10% prevalence of major depression in primary care settings with a substantially higher rate in patients with coexisting medical problems, particularly in those with diseases associated with strong biological or psychologic predispositions to depression (eg, stroke, Parkinson's disease, traumatic brain injury, pancreatic cancer, and other terminal illnesses).

Prevalence of depression varies among age groups. Recent data point to a cohort effect through which current "baby boomers" (age 35–50 years) experience the highest rates of depression of any previous generation. Although the most current epidemiologic findings show a surprisingly low 1-year prevalence rate of major depression in the elderly (1–2%), the rate of major or minor depression in elderly patients who seek treatment in primary care practices is 5%, with rates ranging from 15% to 25% in nursing home residents. Major depression is often misdiagnosed in elderly primary care patients as signs of aging, and cognitive impairment may also complicate accurate diagnosis. Some medications commonly prescribed in the elderly population may actually precipitate the onset of depression. Since the usual age of onset of depression is under 40, an apparent first episode of depression in an older patient should prompt a thorough evaluation to exclude other underlying disease and medication effects.

Depression is often mistakenly believed to be "expected" in the face of stressful life events. Studies of individuals under stress (eg, terminal cancer, natural disaster, etc) do show rates of major depression above the general population rate, but these rates rarely exceed 50%. Although sad or depressed affect is an expected accompaniment of a stressful event, the full syndrome of major depression does not necessarily emerge. Thus, there may be "good reasons" for sadness, but no good reasons to explain away a syndrome of major depression. If such a syndrome emerges following a stressful life situation, the primary care provider should strongly consider the diagnosis of major depression and treat it appropriately.

The term *reactive depression* has historically suggested a mild syndrome without a biological substrate, resulting from a psychologic precipitant and treatable with psychotherapy alone. None of these assumptions are true. A very severe depressive syndrome can result from a stressful event; a biologically predisposed indi-

vidual may suffer major depression in response to a life event; a major depression resulting from a life stress may develop a biological substrate; and a major depression from a life stress may respond, as well or better, to biological therapy than to psychotherapy. Thus, the presence or absence of identifiable precipitants is irrelevant to the diagnosis of major depression, which can be treated pharmacologically whether or not the condition resulted in part from psychological stressors.

A comorbid general medical condition (such as cancer or Parkinson's disease) may seemingly "cause" many of the physical symptoms of major depression, such as fatigue, anorexia, or psychomotor retardation. These symptoms may lead clinicians to discount their relevance and thus disregard the possibility of a treatable depression. Emerging data and the revised American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (*DSM-IV*) criteria for major depression emphasize the importance of including these symptoms in the diagnostic approach to depression in the medically ill. Although an inclusive approach might seem to overdiagnose major depression, studies in stroke, Parkinson's disease, and traumatic brain injury indicate that the problem of overdiagnosis is, if anything, quite low (around 2%).

## ETIOLOGY

Major depression represents a heterogeneous group of disorders, most probably arising from a host of etiologic determinants. Since no clear anatomic, biochemical, or physiologic lesions have been found to explain major depression, most investigators agree that it is a complex psychobiological syndrome that can only be diagnosed on clinical, syndromal criteria. Some promising genetic, biological, and psychosocial studies, however, suggest etiologic possibilities as well as therapeutic interventions.

## GENETIC FACTORS

Research to date identifies a combination of environmental and biological factors underlying severe mood disorders. Apparently, genetic and family experiences each play their roles, though neither are determining factors. For example, even for bipolar disorder, which has very strong genetic loading, monozygotic twins may experience a 50% concordance prevalence rate, whereas dizygotic twins show a 10% concordance rate (about the same as siblings). Recent data from twin studies on depression in women indicate that genetic factors play the strongest

etiologic role in depression, followed by recent (as opposed to early environmental) negative life events. Animal studies, on the other hand, demonstrate that early environmental stress predisposes to biological abnormalities associated with depression that may not emerge until adult life.

## BIOLOGICAL FACTORS

Numerous biological "markers" of depression have been identified. Although these factors may underlie major depression, they do not necessarily "cause" it. Environmental stress can lead to psychic distress precipitating a biological cascade eventuating in major depression. Several biological markers reliably and statistically differentiate groups with and without major depression, but no marker is specific enough to be used diagnostically.

Some markers include endocrine factors: elevated cortisol; inability to suppress endogenous cortisol production after receiving exogenous dexamethasone (DST); blunted response of thyroid-stimulating hormone (TSH) to thyroglobulin-releasing factor (TRF); and increased growth hormone response to prolactin. Central nervous system levels of norepinephrine (NE) and serotonin (5-hydroxytryptamine: 5-HT) may be altered, but more likely, NE or 5-HT receptor function (or both) or number are affected by depression. Platelet imipramine or platelet paroxetine binding have been identified as markers of central serotonin activity. Major depression also impairs sleep physiology, with early induction of REM sleep and overall increase of REM density. Positron emission tomography studies point to anatomically specific metabolic differences between depressed individuals and controls.

## SOCIAL & PSYCHOLOGICAL FACTORS

Significant psychosocial stressors, especially those involving loss, often trigger a depression. The loss of a parent or spouse, the end of a relationship, and events involving loss of self-esteem, such as termination from a job, seem to be especially vulnerable periods for patients. It is important that the primary care provider not overlook or explain away a major depression because of the presence of a major life event. In addition, the absence or perceived lack of social supports increases an individual's vulnerability to depression in the face of life stressors.

The postpartum "blues" typically occurs in 50–80% of women within 1–5 days of childbirth and lasts up to 1 week. This "normal" reaction should be distinguished from postpartum psychosis that occurs in 0.5–2.0/1000 deliveries and typically begins 2–3 days after delivery. It is also distinct from nonpsychotic depression that occurs in 10–15% of women in the first 3–6 months after childbirth.

Table 22-2. Diagnosis of major depression.

1. Depressed mood
2. Anhedonia (lack of interest or pleasure in almost all activities)
3. Sleep disorder (insomnia or hypersomnia)
4. Appetite loss, weight loss; appetite gain or weight gain
5. Fatigue or loss of energy
6. Psychomotor retardation or agitation
7. Trouble concentrating or trouble making decisions
8. Low self-esteem or guilt
9. Recurrent thoughts of death or suicidal ideation
10. Five symptoms from the preceding list, but depressed mood or anhedonia is required. The symptoms must all have been present most of the day, nearly every day for 2 weeks.

## DIAGNOSIS

*DSM-IV* criteria for major depression (MD) require that five out of nine symptoms be present for a 2-week period (Table 22-2). One of these nine symptoms must be either a persistent depressed mood (present most of the day, nearly every day) or pervasive anhedonia (loss of interest or pleasure in living).

Thus, clinicians should realize that a depressed mood is not synonymous with major depression. Depressed mood is neither necessary nor sufficient for a diagnosis of major depression. Sadness (or tearfulness) does not constitute major depression (the four other symptoms described in the following paragraph are necessary), and, conversely, major depression can be diagnosed without the presence of depressed mood (if pervasive anhedonia is present).

Clinical evaluation can be facilitated by organizing these nine symptoms into clusters of four hallmarks: (1) depressed mood; (2) anhedonia; (3) physical symptoms (sleep disorder, appetite problem, fatigue, psychomotor changes); and (4) psychological symptoms (difficulty concentrating or indecisiveness, guilt or low self-esteem, and hopelessness). Physical symptoms predict a favorable response to biological intervention. For example, when middle insomnia is present (awaking at 3 or 4 AM with inability to return to sleep) and when a diurnal variation in mood is present (feeling more depressed in AM), patients are more likely to respond to biological interventions.

## THE MEDICAL INTERVIEW

The medical interview is the key to the assessment of major depression. Efficient assessment involves attention to data-gathering as well as rapport-building functions of the interview. Physicians should observe nonverbal cues: for example, a sad mood may be communicated by downcast eyes, slow speech, wrinkled brow, or tearful affect. When a depressed mood is detected or emotional distress is suspected, physicians

should use open-ended questions and facilitation techniques to allow patients the opportunity to discuss the issues that are troubling them (see Chapter 1).

Physicians screening specifically for depression should focus on anhedonia ("What do you do for a good time?") or sleep ("How is your sleep?"). These questions often yield positive responses, despite the patient's focus on physical complaints or tendency to deny depressed mood. The lack of capacity for pleasure is a central hallmark of major depression.

## BARRIERS TO DIAGNOSIS

### Patient Barriers

**Somatic Presentations:** Many patients with MD present with problems such as pain (headache, backache), fatigue, insomnia, dizziness, or gastrointestinal problems. Such somatizing patients seldom state or even recognize the fact that they may be depressed. In these patients, evaluating both general medical and psychiatric problems simultaneously saves time, expense, and frustration for both physician and patient.

**Stigma:** Many patients and families are reluctant to accept the diagnosis of depression because of its associated social stigma. Physicians sometimes also avoid diagnosing depression because of this stigma. Physicians can help overcome this barrier by understanding and explaining to patients and families that depression is a common and treatable illness, like other medical illnesses. Depression represents a chemical imbalance that can, like diabetes and other medical conditions, be corrected or managed with adequate treatment.

### Clinician Barriers

At least 50% of depressed patients are either undetected or are not adequately treated by primary care providers. Inadequate knowledge and skill, lack of time, reluctance to "open up" new domains of emotional distress, and financial discrimination all operate as barriers to recognition and treatment.

**"Pandora's Box":** Physicians often feel reluctant to pursue psychiatric or emotional problems for fear this will open a "Pandora's box" and take an unreasonable amount of time. Attention to emotional issues, however, can be efficient and cost-effective when physicians respond to patients' emotions and appropriately manage psychiatric disorders. Time can be conserved, while minimizing the number of extended work-ups for nonspecific physical complaints.

**Financial Discrimination:** Providers may avoid the diagnosis and treatment of mental disorders because coding for counseling or pharmacotherapy of depression may not be reimbursed at all or may be reimbursed at lower rates than treatment of general medical conditions.

## SUICIDE

Suicide is one of the top 10 causes of death in all age groups, one of the top 3 causes in young adults and teenagers, and needs to be evaluated in all patients with symptoms of depression. Risk factors for completed suicide include gender (elderly white males are at highest risk), alcoholism, psychosis, chronic physical illness, and lack of social support. Higher risk of suicide has also been noted among adolescents (see Chapter 11) and among gay and lesbian patients (see Chapter 14). Explicit suicidal intent, hopelessness, and a well-formulated plan indicate high risk. In assessing the risk of a stated plan for suicide, clinicians can use the mnemonic **SAL**. Is the method Specific? Is it Available? Is it Lethal? Many patients who eventually commit suicide visit a primary care physician in the month before they take their lives.

The assessment of suicidal ideation is best approached gradually, with general questions like, "Do you sometimes feel that life is not worth living?" Eventually, the patient needs to be asked directly, "Do you ever feel like hurting yourself, or actually taking your own life?" Other approaches to this issue are summarized in Table 22-3.

Physicians are sometimes reluctant to explore suicidal ideation in the mistaken belief that asking about suicide may actually increase a patient's risk. To the contrary, assessment of suicidal tendencies usually reassures patients, reduces anxiety for both patient and provider, and facilitates partnership in suicide prevention.

Once a patient reveals suicidal ideation, the physician must consider psychiatric consultation and hospitalization. This clinical judgment has no absolute decision rules. The presence of risk factors should be kept in mind, but clinical judgment remains primary. If outpatient management is considered, physicians should rely on a "no suicide contract." Although no data on the effectiveness of this technique exists, it represents the standard for practice. The no suicide contract involves asking the patient to promise the physician that he or she will contact the physician (or other appropriate caregiver) if there is a danger of losing control of a suicidal impulse. Clinicians should be cautioned, however, that having obtained a no suicide contract with a patient may give the clinician a false

Table 22-3. Questions for the suicidal patient.

1. How does the future look to you?
2. Do you ever feel that life is not worth living?
3. Do you sometimes feel it doesn't matter whether you live or die?
4. Have you ever considered taking your own life?
5. Have you developed a plan about how you might kill yourself?
6. Are you willing to promise me that you will call me (or this number) if you feel you cannot control an impulse to take your own life?

sense of security. Consequently, it is important to continue assessing suicide risk according to the indicators mentioned earlier throughout the course of the patient's depression.

## SCREENING TOOLS

Studies in primary care have reported that approximately 50% of cases of depression are not diagnosed. Clinicians can miss the diagnosis if they do not perform routine screening on their patients. Screening tools for depression (eg, Zung Depression Scale and the Beck Depression Scale) and other disorders have proven useful in the past for the detection of psychiatric symptoms. These need to be followed by specific physician interviews in order to make the accurate clinical diagnosis. Studies have indicated that these instruments are highly sensitive for detecting depressive disorders but have a low specificity for the actual diagnosis of major depression.

A variety of new and potentially more valuable tools are now available for primary care physicians to help in the assessment and management of mental disorders and particularly in the assessment and management of depression. PRIME-MD was developed as a two-part instrument to assess five *DSM-IV* disorders commonly seen in primary care (depression, anxiety, substance abuse, somatization, and eating disorders). The first part is a paper-and-pencil screen completed independently by patients, followed up by a structured, brief physician interview if the patient scores positive for any of the disorders on the screening instrument. This tool has been shown to have a reliability and validity comparable to an independent psychiatric interview for the five disorders.

The Symptom-Driven Diagnostic System for Primary Care (SDDS-PC) and the *DSM-IV-PC* are two other screening and assessment tools for use in primary care. *DSM-IV-PC* represents an adaptation of the *DSM-IV* for use in primary care. It was developed by task groups of psychiatrists, family physicians, internists, and obstetrician-gynecologists. It focuses on the diagnostic criteria and assessment approaches (with decision trees) for nine categories of common mental disorders as well as common behavioral disturbances encountered in primary care. It has not been fully tested in clinical settings but seems to have great promise.

## PHYSICAL EXAMINATION

There are no specific diagnostic signs of depression. Some nonverbal cues, however, are suggestive (eg, wrinkled brow, downcast eyes, slow speech, psychomotor retardation or agitation, hand wringing, sighing, or shoulder-shrugging). A careful medical history and physical examination is required for the evaluation of depression, at all ages, but especially in the elderly.

## LABORATORY STUDIES

No laboratory studies can definitely diagnose major depression. A laboratory screen (complete blood count, chemistry profile, urinalysis, thyroid-stimulating hormone, and vitamin B<sub>12</sub> levels), however, can rule out other conditions that may mimic or exacerbate depression. In treatment-resistant cases, or when indicated, a computed tomographic (CT) scan, magnetic resonance image (MRI), electroencephalogram (EEG), or lumbar puncture (LP) can be considered, but these studies do not need to be part of the standard work-up. Patients over age 40 usually require an electrocardiogram (EKG) to rule out conduction disturbances or bradycardia, especially if treatment with a tricyclic antidepressant is anticipated.

## DIFFERENTIAL DIAGNOSIS

### Mental Disorders

Other mental disorders also present with symptoms similar to depression and may, therefore, lead to misdiagnosis. In addition, depression often presents in combination with other mental disorders. Thus, knowledge of the other mental disorders common in primary care is essential. In general, the best way to approach the issue of psychiatric comorbidity is to evaluate the patient for major depression and treat the depression if it is present. Modifications of treatment may be necessary depending on the comorbidity present.

### Anxiety Disorders

Anxiety is as common as depression in primary care. Anxiety is present in most cases of major depression, and depressive symptoms are common in anxiety disorders. The most important anxiety disorders for the primary care physician are generalized anxiety disorder (GAD), panic disorder (PD), and obsessive-compulsive disorder (OCD). Central features of these disorders include pervasive and disabling anxiety (GAD), discrete panic attacks (PD), or the presence of unreasonable and recurrent behaviors or thoughts (OCD). Treatment of major depression by itself, however, often helps to resolve or improve these other coexisting conditions (see Chapter 23).

### Somatoform Disorders

Because depression often presents with unexplained bodily complaints, the differentiation between a depressive illness and a somatoform disorder can be difficult (see Chapter 24). Depressive disorders are highly treatable, but somatoform disorders can be more chronic and refractory to treatment. Somatoform disorders are usually managed conservatively with a focus on improved functioning, whereas depression should be treated aggressively with the goal of complete recovery. Any of the somatoform disorders (conversion, somatization, hypochondriasis,

body dysmorphic disorder, and somatoform pain disorder) can present comorbidly with major depression. Most patients with somatization disorder experience a major depression sometime in their lives.

Primary care physicians should focus on recognizing the symptoms of major depression. Despite the presence of a somatoform disorder, appropriate treatment of the MD usually improves the somatoform disorder. With treatment of a comorbid depression, somatoform patients typically feel somewhat better, improve their functioning, and decrease their inappropriate use of general medical services.

### Substance Abuse

Patients with alcoholism or other substance abuse problems commonly present with MD. Physicians should be cautious about treating major depression in the context of substance abuse to avoid further enabling the abuse problem. Rather, the problem of the substance abuse needs aggressive intervention and treatment. Unlike anxiety disorders or somatoform disorders, treatment of MD comorbid with alcoholism does not usually alleviate the substance abuse problem. Physicians need to evaluate patients for substance abuse and design separate treatment programs whether or not MD is present. Mental health referral is usually indicated in such cases (see Chapter 21).

### Personality Disorders

Personality disorders represent enduring character patterns that are deeply ingrained and not generally amenable to alteration (see Chapter 25). They often complicate the diagnosis and management of mood disorders. Because patients with personality disorders can be difficult and demanding, physicians often try to minimize contact with them. Unfortunately, this may lead to avoidance of emotional issues and failure to diagnose depression.

Effective treatment of the MD often improves functioning when the depression coexists with a personality disorder, even if the underlying disorder is not fundamentally changed. Thus, physicians should evaluate the basic symptoms of depression in all distressed individuals, whether or not they have a comorbid personality disorder.

### Dementia

In its early stages, dementia can be difficult to distinguish from depression. Depression leads to reversible cognitive impairment in the form of decreased concentration, memory difficulties, impaired decision-making ability, difficulty planning and organizing, and difficulty getting started on tasks. These are also impairments that can result from an irreversible dementing process. Likewise the effect of dementia on a person's functioning can lead to depressed mood. When diagnostic uncertainty exists,

**Table 22-4.** General medical conditions with high prevalence of depression.

Disease/Condition
Alzheimer's disease
End-stage renal failure
Parkinson's disease
Stroke
Cancer or AIDS
Chronic fatigue
General outpatient
Chronic pain

Source: Adapted, with permission, from Cohen-Cole SA, Kaufman K: Major depression in physical illness: Diagnosis, prevalence, and antidepressant treatment (A ten-year review: 1982-1992). *Depression* 1993;9:181.

clinicians can treat the depressive component (with both medication and counseling) and observe for changes in the patient's cognitive symptom cluster.

### Depression Due to General Medical Conditions or Medications

Approximately 10-15% of all depression is caused by general medical illness. The diagnosis of "depression due to a general medical condition" is recognized by DSM-IV as a psychiatric condition and is considered to be the direct physiologic result of a medical illness, such as hypothyroidism or hyperthyroidism, pancreatic cancer, Parkinson's disease, or left-sided strokes (Table 22-4). Since there are no clear criteria to help guide clinicians in their evaluation, this diagnosis is ultimately made on clinical inference, considering the timing of the depression in relation to the physical illness. The diagnosis becomes "depression due to a general medical condition, with major depressive episode" when five out of nine of the symptoms of major depression are present. Data seem to indicate that standard treatments for major depression are effective in these cases.

Similarly, depression can be caused by exogenous medications (Table 22-5). For example, reserpine has long been known to cause a severe depressive condition in 15% of patients. Of critical importance is the understanding that no medication has been noted to "cause" depression in all patients. It is, therefore, crucial to carefully evaluate the clinical history and link the onset of depressive symptoms to the initiation of new medications or changes in the current regimen.

**Table 22-5.** Medications that can cause depression.

<ul style="list-style-type: none"> <li>• Antihypertensives</li> <li>• Hormones</li> <li>• Anticonvulsants</li> <li>• Steroids</li> <li>• Digitalis</li> <li>• Antiparkinsonian agents</li> <li>• Antineoplastic agents</li> <li>• Antibiotics</li> </ul>
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## TREATMENT

### Communicating With Depressed Patients

The process of the clinician's communication with a depressed patient should take into account the patient's slower rate of cognitive processing. Since busy primary care providers are used to processing information at a high volume, the mismatch between the provider's and the depressed patient's rate of processing can be equivalent to having a 28,800-baud modem interfacing with one that is operating at 1200 baud or slower. Consequently, it is important to present information in smaller chunks and allow silences for the patient to assimilate the information. Empathy skills appropriate to the relationship-building function of the medical interview (see Chapter 1) are important here. A simple reflection by the clinician of how bad the patient is feeling enhances rapport.

### Presenting the Diagnosis

After eliciting symptoms from the patient, the clinician can summarize them as a preface to stating simply that "these symptoms indicate to me that you are suffering from depression." It can be helpful to then add a couple of additional symptoms not mentioned by the patient, but which are often part of the depressed constellation, such as difficulty concentrating or making decisions. By adding these symptoms, the clinician can check out with the patient their presence or absence and, if present, enhance the patient's perception of the clinician's knowledge about this disease.

Since some patients may associate depression with a stigma, it is helpful to explain MD as a common biological disorder. Drawing a picture of a synapse and neurotransmitters may be helpful to some patients. It is often helpful to name famous people, such as Thomas Jefferson or Abraham Lincoln, who are known to have suffered from depression and yet led productive lives.

A crucial part of presenting the diagnosis is to instill hope that depression is a curable illness. The cure involves mobilizing resources in the patient (see the section on "Counseling by Physician") and sometimes external resources such as medication. Indicate that painful depressive symptoms can be relieved in time, and note that "others may notice improvements in you before you notice the change yourself" (see Chapter 6). When adverse life circumstances play a role in the cause of MD, the physician can acknowledge the role played by the stressors, but the doctor must also help the patient understand that treatment of the MD can help him or her cope better with life's adversities.

*Case illustration:* A 45-year-old single woman came in to see her primary care physician complaining of abdominal pain and "nervous exhaustion." In the interview

her physician noted that her affect was flat and that she spoke with long latencies. She was having trouble sleeping, frequently awakening after 4 hours' sleep with perspiration, heart palpitations, and obsessive worries about her job. She had assumed a new job 4 months earlier as manager of a hospital clinic that was converting to a new data management system. After the physician ascertained that the patient was not suicidal, she summarized the patient's concerns and presented her diagnosis in the following dialogue:

DOCTOR: It's obvious that these last few weeks have been like torture for you.

PATIENT: (Tearful) When I go to bed, I dread getting up the next day, . . . and I know I have to hold it together, because the whole clinic is depending on me.

DOCTOR: It sounds like you carry a lot of responsibility. Let's talk about what I think is going on, and then I'd like to get your ideas about that. You've said that you are finding less energy during the day and that you awaken frequently at night, sometimes only getting a few hours' sleep. You tend to judge yourself harshly, and lately you feel guilty that you're not accomplishing more. You've lost interest in things you used to enjoy, and lately all you can think about is your job. You're finding it harder to concentrate, and making simple decisions feels overwhelming. Did I leave out anything?

PATIENT: No . . . I . . . just don't know what's happening to me.

DOCTOR: All these symptoms indicate to me that you're suffering from depression. This is an illness that effects our nervous system in ways that robs us of our usual ability to enjoy the pleasures of life and to have confidence in our abilities. Your depressed mood is leading you to view yourself through a distorted lens that filters out all recognition of your competence and abilities. (Pauses to check patient's response. After head nod from patient, she proceeds as follows) Fortunately, depression is a very treatable illness and there are some very effective treatment strategies you and I can work on together. This may be hard for you to believe right now, because of the hopeless feeling that accompanies depression, but I'm quite confident that within a few weeks you'll be feeling much better about yourself and about life.

### Choice of Treatment

Research indicates that treatment is effective in at least 70% of cases. Treatment can include medication, counseling by the physician, referral to a mental health specialist (psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse practitioner) for psychotherapy, pharmacotherapy, and in some cases electroconvulsive therapy (ECT). Patients may need to be reminded that they deserve to feel better. They should also be told that without treatment, they will probably continue to suffer the same symptoms for a long time.

### Counseling by the Physician

The importance of the doctor-patient relationship cannot be overemphasized for the recognition and treatment of depression, especially in the presence of

suicidal ideation. The physician must convey feelings of concern in order for patients to discuss personal and distressing aspects of their lives. Thus, the primary care physician should be skilled at the recognition and management of emotional distress.

Office counseling by the primary care physician may be helpful to patients with milder forms of depression, including MD. The patient, however, should be notified that this interaction is not formal psychotherapy, unless the practitioner is actually trained in such treatment modalities. Psychotherapeutic situations invariably arouse strong emotions in both patients and physicians. When complex interpersonal issues or strong feelings emerge during office counseling, the physician should seek supervision from a trained therapist or consultation from a colleague.

The acronym SPEAK was developed by one of the authors (JFC) to help primary care physicians offer office counseling to depressed patients (Table 22-6). The five components of SPEAK (Schedule, Pleasurable activities, Exercise, Assertiveness, and Kind thoughts about oneself) are elements in behavioral, interpersonal, and cognitive approaches to psychotherapy. They provide a framework both for patient education and for ongoing supportive counseling by the physician. A one-page handout summarizing the SPEAK approach that can be given to patients is included in Appendix 22-A.

Following a *schedule* counteracts the motivational deficits and anergia that accompany depression. Frontal lobe functions of planning, organizing, and initiating activity are frequently impaired by depression. The physician can advise the patient to plan ahead and fill out a weekly schedule. The instructions are to follow what the schedule says, "whether or not you feel like it," thus making the patient's activities less mood-dependent and more time-contingent. The physician can present a rationale for the schedule, as well as other elements of SPEAK, perhaps using a metaphor like giving a car battery a "jump start" by getting the car moving.

The schedule should include *pleasurable activities* in order to counteract anhedonia and the tendency of depressed patients to withdraw from pleasurable activities. Although initially patients may feel they are "just going through the motions," ultimately involvement in pleasure may operate synergistically with the other elements of SPEAK in mild depression and with antidepressant medication in more severe depression to help restore neurotransmitter/neuroreceptor func-

tion. To stimulate patients' planning of these activities the physician can administer a brief "Pleasant Event Inventory" (see Appendix 22-B), in which the patients are asked to list the 15 activities they find most enjoyable. This can be given as a homework assignment to bring back to a follow-up appointment.

*Exercise*, depending on the medical condition and physical capabilities of the patient, is important as a short-term mood enhancer and long-term prophylaxis against depression. Exercise not only involves kinesthetic movement (breaking somatic rigidity that can play a role in maintaining a depressed mood) but also may release endorphins. The patient should be encouraged to exercise several times a week.

*Assertiveness*, often difficult for depressed individuals because of low self-esteem and a tendency to doubt their own judgment and opinions, is a key behavior in reversing depression. The physician can help the patient distinguish among nonassertive, assertive, and aggressive behaviors. It is helpful to describe assertiveness as "being direct with others about your feelings, opinions, and intentions." The physician can encourage the patient to make small acts of self-assertion (with significant others, friends, strangers) and to reflect on both their mood and interpersonal outcomes. Self-assertion often mobilizes and discharges affect externally, as opposed to depleting energy by inhibiting affect. It may be helpful to recommend some reading, such as Alberti and Emmons' *Your Perfect Right: A Guide to Assertive Behavior*.

*Kind thoughts about oneself* is perhaps the most challenging element of the SPEAK approach for depressed patients. Patients can become more aware of the self-punishing nature of their thoughts. Using an approach developed by Ellis (1977), one can teach patients to trace the origin of a depressed mood to particular recurrent thoughts and to replace the self-punishing thoughts with positive ones, ideally on a three-to-one ratio of positive-to-negative thoughts. The physician can give patients a worksheet, such as the "ABCD Method of Thought Analysis" shown in Appendix 22-C, to review their emotions, activating events, beliefs about those events, and to dispute irrational non-evidence-based beliefs giving rise to negative feelings.

There are two further considerations about the SPEAK approach to physician counseling of depressed patients. First, it is not meant to be a substitute for psychotherapy or medication when they are clearly indicated according to the criteria mentioned elsewhere in this chapter. The primary care provider may consider trying it as a first approach, however, with medication or psychotherapy to be initiated if there is no response. More commonly the SPEAK approach works synergistically with appropriate medication. Second, this approach to counseling does not require an excessive time commitment by the physician. Often the SPEAK approach can be explained to the depressed patient in about 10 minutes, with about

Table 22-6. SPEAK approach to physician counseling for depression.

S	Schedule
P	Pleasurable activities
E	Exercise
A	Assertiveness
K	Kind thoughts about oneself



**Table 22-7. Considerations for acute-phase treatment with psychotherapy alone**

- Less severe depression
- Prior response to psychotherapy
- Incomplete response to treatment with medication alone
- Chronic psychosocial problems
- Availability of trained, competent therapist
- Patient preference

5 minutes devoted to reviewing the relevant elements of SPEAK in follow-up visits.

### Role of Formal Psychotherapy

New psychotherapeutic strategies have been generated as a result of recent interpersonal, behavioral, and cognitive approaches to understanding depressive etiology and pathology. Some of these therapies have been shown to be as effective as medication for the acute-phase treatment of mild to moderate, but not severe, depression. Considerations for choosing psychotherapy alone in the acute phase of treatment are shown in Table 22-7. Psychotherapy may be a useful adjunct to medication for the treatment of depression and may also have a role in prophylactic maintenance therapy for the prevention or delay of future depressive episodes in patients susceptible to recurrences. Consequently, psychotherapy can be useful for women with MD who want to become pregnant and bear a child in a drug-free condition or for other patients with MD who must be medication-free for limited periods.

The clinical criteria for referral to a mental health specialist depend a great deal on the experience and expertise of the primary care physician. Primary care physicians should inform patients at an early stage of treatment that consultation with a mental health specialist may be necessary if the depression does not fully remit. This can make referral at a later stage much more acceptable. Because partial remission is a common occurrence, physicians should make every effort to establish clear indications of pre-depression functioning, and if full return to baseline functioning does not occur, specialist referral should be made. In making the referral, the primary care provider should communicate with the mental health specialist the nature of the depressive symptoms; baseline premorbid functioning; other treatments, including medication, that have been tried previously or are concurrent; and patient understanding and expectations about psychotherapy.

### Medication

Antidepressant medications are indicated for the treatment of major depression and possibly for dysthymia. Approximately two thirds of patients with major depression respond to pharmacotherapy within 3 weeks after reaching a therapeutic plasma level. The proportion of responders can be increased to 90% by switching initial nonresponders to another class of antidepressants or by using augmentation strategies (eg,

addition of lithium). About one third of patients with major depression (usually milder forms) improve with placebo or general support.

Once a decision is made to initiate therapy, the provider should conceptualize treatment of depression as going through three phases. The **acute phase** of treatment lasts approximately 6–12 weeks and has as its goal the reduction and removal of signs and symptoms of depression and the return to a premorbid level of functioning. A partial response at this phase is associated with a higher risk of relapse later. The **continuation phase** of treatment lasts for 4–9 months with the main goal being prevention of relapse. Medication should be continued at full dose. The **maintenance phase** of treatment, lasting 1 year or longer, aims to prevent recurrence in patients with three prior episodes of depression or other special circumstances (see AHCPR guidelines).

Regular visits are essential for the proper care of the depressed patient. Brief weekly or biweekly visits are usually indicated in the beginning of treatment to evaluate dosage, side-effects, and consequential changes in condition. Weekly phone contacts can be periodically substituted for visits, if necessary.

On initiation of treatment, patients should generally not receive more than 1 week's supply of any medication that can be lethal in overdose. Once the patient has become stabilized on a medication, monthly visits are important for support. If maintenance treatment is warranted, quarterly visits may be adequate.

Approximately 50% of patients with one episode of MD suffer a recurrence. Most experts agree, however, that patients should be slowly tapered from antidepressant medications after a first episode of depression, especially if it has not been particularly severe. Thus, 4–9 months after the first episode abates, the medication can be tapered over a period of 6–8 weeks, raising the dose only if prodromal symptoms of depression reappear.

Research now supports the use of prophylactic antidepressant treatment to decrease the likelihood of recurrence once it is recognized that a patient suffers from recurrent major depression (ie, at least three episodes). Maintenance treatment with antidepressants may also be warranted for patients with only two episodes of MD who also meet the following conditions: (1) first-degree relative with bipolar disorder or recurrent major depression; (2) history of recurrence within 1 year after previously effective medication was discontinued; (3) early onset (before age 20) of the first episode; and (4) both episodes were severe, sudden, or life-threatening in the past 3 years. For prophylaxis, full-treatment dosages of antidepressants should be used on a chronic basis.

Controversy exists concerning the extent to which antidepressants may be useful for the treatment of chronic depression (dysthymia) or of minor depression. Although most experts recommend psychotherapy as the initial treatment for dysthymia, emerging

data from randomized clinical trials are pointing to the efficacy of antidepressant medications for this form of depression. Emotional support by the physician may be sufficient for the resolution of an adjustment disorder, but clinical experience indicates that when a patient experiences significant impairment in function (eg, poor work performance, poor sleep, distressed relationships), antidepressant medications may be helpful and should be considered.

**Choosing an Antidepressant:** Table 22-8 summarizes currently available antidepressant medications and their side effect profiles. In selecting an antidepressant medication, the patient's concurrent medical or psychiatric illnesses, history of prior response, use of other medications, patient preference, cost, and side effects should all be taken into account. In general, the various medications have similar efficacy (70–80%), so the key is to be aware of side effects and to exploit them clinically if at all possible.

First-line treatment by the primary care provider should generally be initiated with either a tricyclic antidepressant (TCA) or selective serotonin reuptake inhibitor (SSRI). They are equally efficacious, even in more severe depression, but have very different side effect profiles. Although effective, the monoamine oxidase inhibitors (MAOIs) should not be used in the primary care setting without psychiatric consultation, since they have a number of potentially serious side effects that require close monitoring and thorough patient education. If a patient fails to respond to the first-line therapy, it is usually preferable to switch to a drug from a different class, although there are anecdotal reports that suggest that some patients who fail to respond to one SSRI will respond when switched to another.

Because antidepressant medication may initially in-

crease anxiety or insomnia, especially in patients with GAD, OCD, or PD, it is important to inform patients of this possible, but usually time-limited problem. Such medication-related anxiety or insomnia usually improves rapidly, and adjunctive low-dose sedating medication (eg, hydroxyzine, doxepin or trazodone, clonazepam, or lorazepam) may be used for a short time. Most patients are able to stop these adjunctive medications, but some benefit from continued combination therapy. Care should be exercised in the prolonged use of benzodiazepines, however, because of the possibility of habituation, tolerance, and build-up of drug levels with the use of long-acting agents.

#### Communicating With Patients About Medication:

Patients initiating antidepressant medication for the first time sometimes are concerned about the stigma associated with medication. Some fear getting "hooked" on the medicine or that it will change their personality in some way. It is important to explain that this is a powerful but nonaddictive medicine that can restore the natural balance of neurotransmitters in the brain. It can be helpful to predict for the patient the possibility of the known side effects of the particular antidepressant and to reframe those side effects as an indicator of the drug's potency to achieve the desired results (see Chapter 6). Finally it is important to build a realistic expectation about the tempo of therapeutic effectiveness by letting the patient know that even though the symptoms of depression may persist for a week or two after starting the antidepressant, the healing process has already begun.

#### Heterocyclic Medications and Side Effects:

Heterocyclic medications (see Table 22-8) include the tricyclics, which have been available since the 1950s. Several other agents similar in structure include

Table 22-8. Antidepressant dosages and side effects.

Antidepressants	Sedating Effect	Anticholinergic Effect	Orthostatic Effect	Effective Dosage Range
<b>Heterocyclic Antidepressants (Tricyclics)</b>				
Amitriptyline (Elavil and others)	+++	+++	+++	75–300 mg
Desipramine (Norpramin)	+	+	+	75–250 mg
Doxepin (Sinequan and others)	+++	+++	+++	75–300 mg
Imipramine (Tofranil and others)	++	+++	+++	75–300 mg
Nortriptyline (Pamelor and others)	++	++	+	50–150 mg
Protriptyline (Vivactil)	+	++	+	10–40 mg
Trimipramine (Surmontil)	+++	++	+++	75–300 mg
<b>Other Heterocyclics</b>				
Amoxapine (Asendin)	++	++	++	150–600 mg
Maprotiline (Ludomil)	++	+	++	150–225 mg
Trazodone (Desyrel)	+++	0	++	200–600 mg
<b>SSRIs</b>				
Fluoxetine (Prozac)	0	0	0	20–80 mg
Paroxetine (Paxil)	0	+	0	20–50 mg
Sertraline (Zoloft)	0	0	0	50–200 mg
<b>Other New Agents</b>				
Bupropion (Wellbutrin)	0	0	0	150–450 mg
Venlafaxine (Effexor)	+	0	0	75–375 mg
Nefazodone (Serzone)	+	0	0	300–600 mg

0 = None; + = Slight; ++ = Moderate; +++ = Marked.

maprotiline, amoxapine, and trazodone. The heterocyclic antidepressants are similar in side effects, dosing strategies, and efficacy, however, Desipramine and Nortriptyline tend to be better tolerated by most patients. Additional visits and other medical procedures are sometimes required with the use of heterocyclics making their overall health care costs about equal to that of the SSRIs.

Heterocyclic medications are started at low doses and gradually increased to therapeutic levels. Although serum antidepressant levels are available for many of these agents, nortriptyline is the one agent with a true "therapeutic window," such that levels below and above the window are less likely to lead to remission of depressive symptoms. Physicians must assess each individual cautiously since patients with high or low blood levels may do very well clinically. For problematic situations, consultation with a psychiatric expert may be advisable. Patients need to be informed that such medications may take up to 3 weeks to reach therapeutic levels, and, therefore, patients generally will not notice immediate positive effects of treatment.

When opting for a heterocyclic antidepressant, it is generally best to use a secondary amine (desipramine or nortriptyline) and avoid the parent tertiary amines (eg, amitriptyline and imipramine) as they have more severe side effects. It is advisable to start with a low dosage and gradually titrate up as tolerated. For example, start desipramine at 25–50 mg at bedtime for 3 days and increase by 25-mg increments every 2–3 days until the patient reaches a therapeutic dose of at least 150 mg once a day. Heterocyclics can be given once a day (generally in the evening) to minimize side effects. There should be some beneficial effects after 2–3 weeks, with a full therapeutic response occurring after 4–6 weeks. If there is little or no response after an appropriate interval on an appropriate dose, check a level and increase the dose as indicated. The most common error leading to "treatment failure" with the heterocyclics is inadequate dosing. There is no reason to follow levels, however, in patients with an appropriate response and minimal side effects.

The heterocyclic antidepressants have varying degrees of problematic side effects, including anticholinergic, antihistaminic, antiadrenergic, and quinidine-like effects.

**Anticholinergic Side Effects:** Anticholinergic effects include urinary retention, constipation, dry mouth, confusion, tachycardia, and increased ocular pressure. These effects can be annoying, or sometimes dangerous, depending on the physical condition of the patient. Ileus and peritoneal perforation can be fatal. Increased ocular pressure may cause blindness in patients with narrow-angle glaucoma, and tachycardia can precipitate angina in patients with coronary artery disease. As can be seen in Table 22–8, Desipramine and Nortriptyline have far fewer anticholinergic side effects.

**Antihistaminic Side Effects:** The antihistaminic side effects cause sedation and inhibition of gastric acid secretion. The potent antihistaminic action of tricyclic agents such as doxepin have led to its use for urticaria, as well as for providing better sedation. Desipramine may have more prominent sympathomimetic effects of agitation and insomnia, and it can be used if a less sedating antidepressant is desired.

**Antiadrenergic Side Effects:** Antiadrenergic effects cause postural hypotension, which can be quite dangerous in the medically ill or elderly. Nortriptyline seems to be the safest of the heterocyclics in this regard.

**Quinidine-like Side Effects:** All heterocyclics (except trazodone) have quinidine-like effects. They delay conduction across the His bundle and increase the QT interval on an EKG. Patients with bundle branch block and increased conduction time can experience higher degrees of heart block when given these medications. A corrected QT interval of 0.44 is generally considered the maximum length for the safe use of tricyclic antidepressants. Specialty consultation should be sought when using these agents in patients with intervals greater than 0.44. In general, use of TCAs should be avoided in patients with significant conduction abnormalities.

Among the tricyclics, desipramine (a metabolite of imipramine) and nortriptyline (a metabolite of amitriptyline) are the least anticholinergic, the least sedating, and the least likely to cause postural hypotension. Among the heterocyclic medications, trazodone is notable because it does not cause anticholinergic or conduction problems and has very low lethality in overdose. Trazodone, however, is quite sedating and may also cause postural hypotension and, rarely, priapism (see Table 22–8).

**New Agents and Side Effects:** Selective serotonin reuptake inhibitors (SSRIs) and other newer agents have revolutionized psychiatric practice, especially for treatment of depression in the elderly and in patients with comorbid general medical illnesses. Many patients too physically ill to be safely treated in the 1960s and 1970s can now receive these antidepressants without fear of dangerous side effects. These agents have an extraordinarily low suicide risk from overdose.

The most widely used of these newer agents include the SSRIs (fluoxetine, paroxetine, fluvoxamine, and sertraline), bupropion, venlafaxine, and nefazodone. Several new SSRIs will be available in the next few years. These new agents are remarkably safe since they do not cause postural hypotension or cardiac conduction delay. Antihistaminic side effects are minimal or nonexistent, and, with the exception of paroxetine (which has very mild anticholinergic effects), none of these new agents have any appreciable anticholinergic effects.

The wide range of effective antidepressants can

make the choice of agent difficult. Fluoxetine has been the most widely used, in more than 18 million patients through 1994. Despite some speculation, all available data suggest that fluoxetine is not more highly associated with violence or suicidal tendencies than any other antidepressant or, for that matter, than with placebo.

Fluoxetine has the longest half-life (24–72 hours) of the new agents and has a long-acting active metabolite (half-life of 7 days). A long half-life may be problematic for some patients, experiencing side effects or drug interactions, but it has not appeared to be a significant problem in clinical practice. In fact, with a long-acting agent like fluoxetine, missing doses does not lead to breakthrough depressive symptoms and also permits dosing every other day, when indicated. When the drug is to be withdrawn, doses can eventually be given once or twice a week, to allow for very smooth tapering. SSRIs with half-lives of 24 hours (sertraline and paroxetine) allow the convenience of once-a-day dosing but result in rapid washout. Bupropion, venlafaxine, and nefazodone (and their metabolites) have shorter half-lives of 4–14 hours, so they must be given at least twice a day.

The starting dose of the three main SSRIs is often the effective treatment dose. This is most clearly the case for fluoxetine at 20 mg, but may also be true for paroxetine at 20 mg, and for sertraline at 50 mg. Patients not responding to the starting doses of SSRIs after 1 month should be given increased doses. Elderly patients and patients with liver disease or other general medical illness often require smaller starting doses, for example, one half of the recommended dose.

Clinicians need to be aware that SSRIs inhibit the cytochrome P-450 system, potentially causing problems with medications metabolized in the liver, such as anticonvulsants, digitalis, and warfarin (Coumadin), and may lead to increased drug levels. Reports conflict regarding which SSRIs are most or least likely to cause this problem, but paroxetine seems to be the most potent inhibitor and sertraline the least potent inhibitor of the 2D6 liver enzyme system. The SSRIs and the other new agents, however, also may have variable effects on other liver enzyme systems such as the 3A4 or 1C.

Nefazodone, in particular, seems to have little effect on any system other than 3A4, which can be a particular problem for use with other drugs metabolized by this system, such as terfenadine (Seldane), astemizole (Hismanal), erythromycin, and ketoconazole. To avoid dangerous pharmacokinetic interactions, it may be necessary to initiate treatment with very low doses, especially in the frail elderly. Side effects, blood levels, and clinical indicators of toxicity must be carefully monitored. Bupropion and venlafaxine, on the other hand, do not seem to inhibit these enzymes.

The use of bupropion in primary care is somewhat problematic because its use may be associated with a

1–4% prevalence of seizures, which may be slightly more common than with other antidepressants. Bupropion should be given in divided doses, and should not be given to individuals at risk for seizures (eg, head trauma history). It is never given in a single dose greater than 150 mg, and the starting dose (75 mg bid or tid) should be increased slowly (once a week) to therapeutic levels of 300–450 mg/day to minimize the risk of seizures. The medication should also not be given to bulimic patients (patients who gorge food and often induce vomiting) because of a possible increased seizure risk. Despite this small but potential risk, bupropion is useful because it does not cause sexual problems often associated with other antidepressants.

The SSRIs may cause side effects like anxiety, insomnia, GI distress, agitation, and sexual difficulties. These are usually mild, occur in less than 20% of patients, and usually do not lead to discontinuation of medication. Adjunctive use of a sedating antihistamine (diphenhydramine or hydroxyzine), sedating antidepressant (trazodone or doxepin), or anxiolytic (eg, clonazepam or lorazepam) can be helpful. When prescribing a sedating serotonergic antidepressant (such as trazodone) along with an SSRI, low doses of the sedating agent should be used to avoid a possible serotonergic syndrome. These adjunctive agents should usually be discontinued after a short time, but continued treatment with two agents is sometimes indicated. If a long-acting benzodiazepine is used in the elderly, care must be exercised to avoid a build-up of medication that can lead to confusion, sedation, or falls after several weeks of treatment.

*Case illustration (Contd.):* In the previous case of the 45-year-old clinic manager, the physician, after presenting the diagnosis, reviewed the SPEAK approach to the treatment of depression. She gave the patient the handout to read (Appendix 22-A). Discussion revealed that the patient had neglected pleasurable activities and that she engaged in negative self-judgments about her productivity, leading to a compulsive work schedule and failure to attend to the symptoms of fatigue. They decided that the P and K components of SPEAK deserved special attention, and the physician prescribed a long 4-day “strategic retreat” from work so the patient could implement a schedule that included exercise, pleasurable activities, and reflection on her thought processes, using the Pleasant Event Inventory (Appendix 22-B) and the ABCD Thought Analysis (Appendix 22-C). The physician discussed the advisability of antidepressant medication and the possibility of referral to a psychotherapist, but the patient was reluctant at this time to take these steps. The physician then negotiated an agreement that the patient would try the new schedule, that she would come back for an appointment in 2 weeks, and that if there was no improvement in sleep patterns and mood, she would undergo a trial of antidepressant medication.

The patient returned in 2 weeks, having forced herself to schedule in pleasurable activities and exercise, and limiting her work hours to a 40-hour week. Her symp-

toms of dysphoria and nocturnal awakening persisted. As they had agreed, the patient then began a trial of an SSRI in the morning and trazodone 50 mg at bedtime to aid in sleep. Within 4 days, a phone call to the doctor indicated that her sleep had improved dramatically. At an appointment 2 weeks later the patient showed improved affect and she reported feeling better. She indicated she was interested in pursuing psychotherapy to change her negative self-evaluations. The physician referred her to a psychotherapist for short-term therapy focused on altering these thought processes.

The patient showed complete resolution of symptoms in 6 weeks. Trazodone was discontinued, and she was maintained on the SSRI for 6 months. During that time she underwent eight sessions of psychotherapy, which resulted in increased self-awareness of her thought processes and a method to shift her thinking in a positive direction. She was seen for two additional therapy sessions in the month after discontinuing the SSRI to consolidate the gains she had made and monitor her for any recurrence of symptoms. At 9 months she reported to her primary care physician that she remained symptom-free and that she was taking a 2-week vacation to the Caribbean.

### Antidepressants in the Elderly and Medically

**III:** For many of the reasons enumerated earlier, the new agents have generally become the agents of choice in the elderly and in the medically ill. Among heterocyclic agents, the safest agents are nortriptyline and desipramine, which are still widely used because of their relatively low anticholinergic and antiadrenergic side effects. They are also widely used as second-line treatment choices and play a role in the treatment of refractory depression, either as adjunctive or alternative treatments.

Dosing strategies in the elderly and medically ill are to "start low and go slow." Pharmacokinetically, these agents are metabolized more slowly, resulting in accumulation and toxicity. Increased pharmacodynamic effects in the elderly may result from lower albumin levels, which lower protein binding.

### Electroconvulsive Therapy (ECT)

ECT is still the most effective means available for the treatment of refractory depression. It is the treatment of choice for patients with psychotic depression, depression refractory to pharmacotherapy, and for some patients who are acutely suicidal. Despite prejudices and fears about ECT, new methods of administration have proven it to be a safe and effective treatment modality. In fact, ECT can be safer than antidepressant medication in the elderly. Some short-term memory loss is common, but research indicates that this reverts to normal in virtually all patients. In some cases, ECT can be life-saving and should not be denied to patients because of poor understanding or unrealistic fear. ECT does not lead to permanent remission of depression in patients susceptible to recurrence. Thus, patients with recurrent depression who receive ECT should receive either prophylactic medication after a course of therapy (as an outpatient) or maintenance ECT.

### MANAGED CARE

The time and organizational pressures of managed care settings may promote even further underdiagnosis and undertreatment of depression in primary care. Health services research indicates that fee-for-service and psychiatric settings may be more effective than prepaid settings for both the recognition and the treatment of major depression. With the sustained growth of capitation and managed care, however, new systems need to be developed to align clinical and financial incentives to increase the accurate assessment and optimal management of depression in primary care. Since depression is associated with increased use of health care services, as well as increased morbidity and mortality, attention to improving the assessment and treatment of depression in primary care should become a high priority for adding value to health care and improving the quality of patient's lives.

### SUGGESTED READINGS

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### Appendix 22-A. Overcoming your depression: The SPEAK approach.

#### S Schedule:

Make a weekly schedule for yourself, with columns for each day of the week and rows for the hours of the day. Using a pencil (so you can make changes) make a plan for activities you will do each hour. Some of the times will already be structured for you, eg, at work. Focus especially on the times that are currently unstructured. Start with things you know you usually do, eg, eating meals, preparing meals. Include on the schedule time to do household chores and errands, but also include times for fun activities and exercise. Because temporarily you may not feel the motivation or desire to do any of these things, follow what the schedule says whether or not you feel like doing it. Sometimes you might feel like you are just going through the motions. When the time comes to switch to another activity, do so whether or not you have completed the previous task. You are making progress by putting in time on all these activities, not by getting through your "to do" list. Proceeding in this way will help you move out of depression by getting yourself moving through the day.

#### P Pleasurable activities:

Some of the items on your schedule should be activities that previously were fun for you before you became depressed. You might have identified some of these pleasures on the Pleasant Events Inventory. For the time being you may feel you are just going through the motions in these activities. When we are depressed the part of the brain that allows us to feel pleasure is not functioning smoothly, so it is important to have a "jump start." You should plan something each day that would normally be fun and make yourself do it.

#### E Exercise:

Aerobic exercise increases oxygen and circulation to the brain and counteracts the hormonal changes caused by depression. It helps activate the natural pharmacy in your brain that will work with other parts of your treatment to help you come out of depression. Times for daily exercise should be included on your schedule. Running, swimming, bicycling, aerobic dancing, and walking are all forms of exercise that will help.

#### A Assertiveness:

This involves being direct with other people in your communication. Practice letting others know your feelings, needs, wants, opinions, and choices. This is more difficult when we are depressed, because we tend to doubt our own judgment. Or we might hold back because we are afraid others will think poorly of us. These thoughts are a product of depression, so it is necessary to act as if you were confident, even though inside you don't feel it. It takes more energy to hold in feelings than to express them. You might find that by stating clearly what you need or by saying "No" to what you don't want will help increase your energy and confidence. Read *Your Perfect Right* by Alberti and Emmons.

#### K Kind thoughts about yourself:

Since depression leads us to think self-punishing thoughts, it is very important to increase your awareness of when this is happening and to replace the negative thoughts with positive ones. Most of the time these negative thoughts are strongly held opinions that are not based on evidence. It is like carrying a negative, opinionated relative with you wherever you go. Once you become aware of this pattern of thoughts, begin to analyze them using the ABCD worksheet. You might write the most persistent negative thought on a 3 x 5 card. Then turn the card over and write three positive thoughts that you could replace it with. Carry this card with you and refer to it frequently. It takes about three positive statements to counteract the effect of one negative statement.

## Appendix 22-B. Pleasant Events Inventory.

Pleasant Event <sup>1</sup>	With Whom <sup>2</sup> A = Alone P = Partner F = Family O = Other People	How Often <sup>3</sup>	Last Time <sup>4</sup>	\$ Amount if Costs Money <sup>5</sup>
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

<sup>1</sup> List the activities or events that have brought you the most pleasure over the years.

<sup>2</sup> Indicate with whom you like to share the pleasure.

<sup>3</sup> Indicate how often you do this activity.

<sup>4</sup> How long has it been since you engaged in this activity. If it has been months or years, perhaps you should schedule time for it soon.

<sup>5</sup> Make a \$ sign if the pleasure costs money. You might be surprised at how many of your pleasures are free.

<u>Activating Event</u>	<u>Belief</u>	<u>Consequence</u>	<u>Dispute</u>
#2	#3	#1	#4
What happened before "C" ?	What am I telling myself about "A" ?	What am I feeling?	Where's the evidence for "B"?

1. Start your analysis in the C (*consequence*) column, by writing the negative emotion you have been feeling today. This emotion (e.g., sadness) is a consequence of something else.
2. List in the A column the *activating event* that triggered the emotion. Answer the question, "What happened before I started feeling sad?" An example might be that a close friend did not reply when you said hello.
3. Now move to the B column and write down your *belief* about the activating event. This belief is the actual cause of your negative emotion. Answer the question, for example, "What am I telling myself about my friend ignoring me?" This answer will often be an irrational judgment not based on evidence, e.g., "He's rejecting me," or more generally, "I'm a rejectable person."
4. The final step is to *dispute* the irrational belief by asking, "Where's the evidence for the statement in B?" Then write down a statement in Column D that is a more appropriate, less self-punishing belief about the activating event. For example, you might write down, "My friend was distracted because he's been under a lot of stress lately."

1. Start your analysis in the C (*consequence*) column, by writing the negative emotion you have been feeling today. This emotion (e.g., sadness) is a consequence of something else.
2. List in the A column the *activating event* that triggered the emotion. Answer the question, "What happened before I started feeling sad?" An example might be that a close friend did not reply when you said hello.
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## 15 Styles of Distorted Thinking

### 1. Filtering

This distortion is characterized by a sort of tunnel vision—looking at only one element of a situation to the exclusion of everything else. A single detail is picked out and the whole event or situation is colored by this detail. A draftsman who was uncomfortable with criticism was praised for the quality of his recent detail drawings and asked if he could get the next job out a little quicker. He went home depressed, having decided that his employer thought he was dawdling. He selected only one component of the conversation to respond to. He simply didn't hear the praise in his fear of possible deficiency.

Each person has his own particular tunnel to look through. Some are hypersensitive to anything suggesting loss, and blind to any indication of gain. For others, the slightest possibility of danger sticks out like a barb in a scene that is otherwise warm with contentment. Depressed people select elements suggesting loss from their environment, those prone to anxiety select danger, and those who frequently feel angry select evidence of injustice.

The process of remembering can also be very selective. From your entire history and stock of experience, you may habitually remember only certain kinds of events. As a result, you may review your past and re-experience memories that characteristically leave you angry, anxious, or depressed.

By the very process of filtering you magnify and "awfulize" your thoughts. When you pull negative things out of context, isolated from all the good experiences around you, you make them larger and more awful than they really are. The end result is that all your fears, losses, and irritations become exaggerated in importance because they fill your awareness to the exclusion of everything else. Key words for this kind of filtering are "terrible . . . awful . . . disgusting . . . horrendous," and so on. A key phrase is "I can't stand it."

### 2. Polarized Thinking

The hallmark of this distortion is an insistence on dichotomous choices: You tend to perceive everything at the extremes, with very little room for a middle ground. People and things are good or bad, wonderful or horrible. This creates a black and white world, and because you miss all the nuances of gray, your reactions to events swing from one emotional extreme to another. The greatest danger in polarized thinking is its impact on how you judge yourself. If you aren't perfect or brilliant, then you must be a failure or an imbecile. There is no room for mistakes or mediocrity. A charter bus driver told himself he was a real loser when he took the wrong freeway exit

and had to drive several miles out of his way. One mistake and he was incompetent and worthless. A single parent with three children was determined to be strong and "in charge." The moment she felt tired or slightly anxious, she began thinking of herself as weak, felt disgusted with herself, and criticized herself in conversations with friends.

### 3. Overgeneralization

In this distortion you make a broad, generalized conclusion based on a single incident or piece of evidence. One slipped stitch means "I'll never learn how to sew." A rejection on the dance floor means "Nobody would ever want to dance with me." If you got sick on a train once, never take a train again. If you got dizzy on a sixth floor balcony, never go out there again. If you felt anxious the last time your husband took a business trip, you'll be a wreck every time he leaves town. One bad experience means that whenever you're in a similar situation you will repeat the bad experience.

This distortion inevitably leads to a more and more restricted life. Overgeneralizations are often couched in the form of absolute statements, as if there were some immutable law that governs and limits your chances for happiness. You are overgeneralizing when you absolutely conclude that "*Nobody* loves me... I'll *never* be able to trust anyone again... I will *always* be sad... I could *never* get a better job... *No one* would stay my friend if they really knew me." Your conclusion is based on one or two pieces of evidence and carefully ignores everything you know about yourself to the contrary. Cue words that indicate you may be overgeneralizing are all, every, none, never, always, everybody, and nobody.

### 4. Mind Reading

When you mind read you make snap judgments about others: "He's just acting that way because he's jealous... she's with you for your money... he's afraid to show he cares." There's no evidence, but it just *seems* right. In most instances, mind readers make assumptions about how other people are feeling and what motivates them. For example, you may conclude, "He visited her three times last week because he was (a) in love, (b) angry at his old girlfriend and knew she'd find out, (c) depressed and on the rebound, (d) afraid of being alone again." You can take your choice, but acting on any of these arbitrary conclusions may be disastrous.

As a mind reader, you also make assumptions about how people are reacting to things around them, particularly how they are reacting to you. "This close he sees how unattractive I am... she thinks I'm really immature... they're getting ready to fire me." These assumptions are usually untested. They are born of intuition, hunches, vague misgivings, or one or two past experiences, but they are nevertheless believed.

Mind reading depends on a process called projection. You imagine that people feel the same way you do and react to things the same way you do. Therefore, you don't watch or listen closely enough to notice that they are

actually different. If you get angry when someone is late, you imagine everyone acts that way. If you feel excruciatingly sensitive to rejection, you expect most people to feel the same. If you are very judgmental about particular habits and traits you assume others share your belief. Mind readers jump to conclusions that are true for them without checking whether they are true for the other person.

### 5. Catastrophizing

If you catastrophize, a small leak in the sailboat means it will surely sink. A contractor who gets underbid concludes he'll never get another job. A headache suggests that brain cancer is looming. Catastrophic thoughts often start with the words "what if." You read a newspaper article describing a tragedy or hear gossip about some disaster befalling an acquaintance. As a result you start wondering if it will happen to you. "What if I break my leg skiing... What if they hijack my plane... What if I get sick and have to go on disability... What if my son starts taking drugs?" The list is endless. There are no limits to a really fertile catastrophic imagination.

### 6. Personalization

The chapter began with an example of personalization. It is the tendency to relate everything around you to yourself. A somewhat depressed mother blames herself when she sees any sadness in her children. A recently married man thinks that every time his wife talks about tiredness she means she is tired of him. A man whose wife complains about rising prices hears the complaints as attacks on his abilities as a breadwinner.

A major aspect of personalization is the habit of continually comparing yourself to other people: "He plays piano so much better than I do... I'm not smart enough to go with this crowd... She knows herself a lot better than I do... He feels things so deeply while I'm dead inside... I'm the slowest person in the office... He's dumb (and I'm smart)... I'm better looking... They listen to her but not to me." The opportunities for comparison never end. The underlying assumption is that your worth is questionable. You are therefore continually forced to test your value as a person by measuring yourself against others. If you come out better, you have a moment's relief. If you come up short, you feel diminished.

The basic thinking error in personalization is that you interpret each experience, each conversation, each look as a clue to your worth and value.

### 7. Control Fallacies

There are two ways you can distort your sense of power and control. You can see yourself as helpless and externally controlled, or as omnipotent and responsible for everyone around you.

Feeling externally controlled keeps you stuck. You don't believe you can really affect the basic shape of your life, let alone make any difference in the world. Everywhere you look you see evidence of human helplessness. Someone or something else is responsible for your pain, your loss, and your failure. They did it *to* you. You find it difficult to strive for solutions because they probably wouldn't work anyway. An extreme example of this fallacy is the person who walks through skid row wearing three diamond rings and a \$500 watch. He feels helpless and resentful when he gets mugged. He can't imagine how he had anything to do with it. He was the passive victim. The truth of the matter is that we are constantly making decisions, and that every decision affects our lives. In some way, we are responsible for nearly everything that happens to us.

The opposite of the fallacy of external control is the fallacy of omnipotent control. If you experience this distortion, you feel responsible for everything and everybody. You carry the world on your shoulders. Everyone at work depends on you. Your friends depend on you. You are responsible for many people's happiness and any neglect on your part may leave them lonely, rejected, lost, or frightened. You have to right all wrongs, fill every need, and balm each hurt. And if you don't, you feel guilty. Omnipotence depends on three elements: a sensitivity to the needs of people around you, an exaggerated belief in your power to fill those needs and the expectation that you, and not they, are responsible for filling those needs.

### 8. Fallacy of Fairness

This distorted thinking style hinges on the application of legal and contractual rules to the vagaries of interpersonal relations. The trouble is that two people seldom agree on what fairness is, and there is no court or final arbiter to help them. Fairness is a subjective assessment of how much of what one expected, needed, or hoped for has been provided by the other person. Fairness is so conveniently defined, so temptingly self-serving, that each person gets locked into his or her own point of view. The result is a sense of living in the trenches and a feeling of ever-growing resentment.

The fallacy of fairness is often expressed in conditional assumptions: "If he loved me, he'd do the dishes...if he loved me, he'd help me to orgasm...if this was a real marriage, she'd hike with me and learn to like it...if he cared at all, he'd come home right after work...if they valued my work here, they'd get me a nicer desk."

It is tempting to make assumptions about how things would change if people were only fair or *really* valued you. But the other person hardly ever sees it that way and you end up causing yourself a lot of pain.

### 9. Emotional Reasoning

At the root of this distortion is the belief that what you feel must be true. If you *feel* like a loser, then you must *be* a loser. If you feel guilty, then you

must have done something wrong. If you feel ugly, then you must be ugly. If you feel angry, someone must have taken advantage of you.

All the negative things you *feel* about yourself and others must be true because they feel true. The problem with emotional reasoning is that emotions by themselves have no validity. They are products of what you think. If you have distorted thoughts and beliefs your emotions will reflect those distortions. Always believing your emotions is like believing everything you see in print.

## 10. Fallacy of Change

The only person you can really control or have much hope of changing is yourself. The fallacy of change, however, assumes that other people will change to suit you if you just pressure them enough. Your attention and energy are therefore focused on others because your hope for happiness lies in getting them to meet your needs. Strategies for changing others include blaming, demanding, withholding, and trading. The usual result is that the other person feels attacked or pushed around and doesn't change at all.

The underlying assumption of this thinking style is that your happiness depends on the actions of others. In fact, your happiness depends on the many thousands of large and small decisions you make during your life.

## 11. Global Labeling

Your supermarket stocks rotten food at ripoff prices. A person who refused to give you a lift home is a total jerk. A quiet guy on a date is labeled a dull clam. Republicans are a bunch of money-hungry corporation toadies. Your boss is a gutless imbecile.

Each of these labels may contain a grain of truth. Yet it generalizes one or two qualities into a global judgment. The label ignores all contrary evidence, making your view of the world stereotyped and one-dimensional.

## 12. Blaming

There's such relief in knowing who's to blame. If you are suffering, someone must be responsible. You're lonely, hurt, or frightened and someone provoked those feelings. A man got angry because his wife suggested he build the fence he'd been meaning to put up. She ought to have known how tired he was—she was being totally insensitive. The problem was that he expected her to be clairvoyant, to read his mind, when it was his responsibility to inform her of his fatigue and say no.

Blaming often involves making someone else responsible for choices and decisions that are actually your own responsibility. A woman blamed the butcher for selling hamburger that was always full of fat. But it was really her problem: she could have paid more for leaner meat, or gone to a different butcher. In blame systems, somebody is always doing it to you and you have no responsibility to assert your needs, say no, or go elsewhere for what you want.

Some people focus blame exclusively on themselves. They beat themselves up constantly for being incompetent, insensitive, stupid, too emotional, etc. They are always ready to be wrong. One woman felt she had spoiled her husband's entire evening when she caused a fifteen minute delay in getting to a party. Later when the party broke up early she decided that she had bored everybody.

### 13. Shoulds

In this distortion, you operate from a list of inflexible rules about how you and other people should act. The rules are right and indisputable. Any deviation from your particular values or standards is bad. As a result, you are often in the position of judging and finding fault. People irritate you. They don't act right and they don't think right. They have unacceptable traits, habits, and opinions that make them hard to tolerate. They should *know* the rules and they should follow them. One woman felt that her husband *should* want to take her on Sunday drives. A man who loved his wife *ought* to take her to the country and then out to eat in a nice place. The fact that he didn't want to go meant that he "only thought about himself."

Cue words indicating the presence of this distortion are should, ought, or must. In fact, Albert Ellis has dubbed this thinking style "musterbation."

Not only are other people being judged, but you are also making yourself suffer with shoulds. You feel compelled to do something, or be a certain way, but never bother to ask objectively if it really makes sense. The famous psychiatrist Karen Horney called this the "tyranny of shoulds."

Here is a list of some of the most common and unreasonable shoulds:

- I should be the epitome of generosity, consideration, dignity, courage, unselfishness.
- I should be the perfect lover, friend, parent, teacher, student, spouse.
- I should be able to endure any hardship with equanimity.
- I should be able to find a quick solution to every problem.
- I should never feel hurt, I should always be happy and serene.
- I should know, understand, and foresee everything.
- I should always be spontaneous and at the same time I should always control my feelings.
- I should never feel certain emotions, such as anger or jealousy.
- I should love my children equally.
- I should never make mistakes.
- My emotions should be constant—once I feel love I should always feel love.
- I should be totally self-reliant.
- I should assert myself and at the same time I should never hurt anybody else.
- I should never be tired or get sick.
- I should always be at peak efficiency.

#### 14. Being Right

In this distortion you are usually on the defensive. You must continually prove that your viewpoint is correct, your assumptions about the world accurate, and all your actions correct. You aren't interested in the possible veracity of a differing opinion, only in defending your own. Every decision you make is right, every task you perform is done competently. You never make mistakes.

Your opinions rarely change because you have difficulty hearing new information. If the facts don't fit what you already believe you ignore them.

An auto mechanic got in the habit of stopping at the bar for three or four drinks on the way home. Frequently he got in after seven, and his wife never knew when to have dinner ready. When she confronted him he got angry and said that a man has a right to relax. She had it soft while he was pulling off cylinder heads all day. The mechanic had to be right and couldn't comprehend his wife's viewpoint.

Having to be right makes you very hard of hearing. It also makes you lonely because being right seems more important than an honest, caring relationship.

#### 15. Heaven's Reward Fallacy

In this framework for viewing the world you always do the "right thing" in hope of a reward. You sacrifice and slave, and all the while imagine that you are collecting brownie points that you can cash in some day.

A housewife cooked elaborate meals for her family and did endless baking and sewing. She drove her children to all their afterschool activities. The house was immaculate. She carried on for years, all the while waiting for some kind of special reward or appreciation. It never came. And she became increasingly hostile and bitter. The problem was that while she was doing the "right thing" she was physically and emotionally bankrupting herself. She had become a crab and no one wanted to be around her.

**Acknowledgement:** Several of these distortions are drawn from the work of other cognitive therapists. From Aaron Beck come Filtering (selective abstraction), Polarized Thinking, Overgeneralization, Personalization, and Mind Reading (arbitrary inference). From David Burns' work comes the concept of Emotional Reasoning.

## Instructions

As you read through the distortions you will notice that you have favorite ones. Others you will rarely if ever indulge in. Your high-frequency distortions are the ones you need to sensitize yourself to so that your inner alarm sounds whenever they come up.

Before going on, read and familiarize yourself with the chart summarizing these 15 styles of distorted thinking. In the next section you will get some practice identifying them.

## Summary

### 15 Styles of Distorted Thinking

1. **Filtering:** You take the negative details and magnify them while filtering out all positive aspects of a situation.
2. **Polarized Thinking:** Things are black or white, good or bad. You have to be perfect or you're a failure. There is no middle ground.
3. **Overgeneralization:** You come to a general conclusion based on a single incident or piece of evidence. If something bad happens once you expect it to happen over and over again.
4. **Mind Reading:** Without their saying so, you know what people are feeling and why they act the way they do. In particular, you are able to divine how people are feeling toward you.
5. **Catastrophizing:** You expect disaster. You notice or hear about a problem and start "what ifs:" What if tragedy strikes? What if it happens to you?"
6. **Personalization:** Thinking that everything people do or say is some kind of reaction to you. You also compare yourself to others, trying to determine who's smarter, better looking, etc.
7. **Control Fallacies:** If you feel externally controlled, you see yourself as helpless, a victim of fate. The fallacy of internal control has you responsible for the pain and happiness of everyone around you.
8. **Fallacy of Fairness:** You feel resentful because you think you know what's fair but other people won't agree with you.
9. **Blaming:** You hold other people responsible for your pain, or take the other tack and blame yourself for every problem or reversal.
10. **Shoulds:** You have a list of ironclad rules about how you and other people should act. People who break the rules anger you and you feel guilty if you violate the rules.
11. **Emotional Reasoning:** You believe that what you feel must be true—automatically. If you *feel* stupid and boring, then you must *be* stupid and boring.
12. **Fallacy of Change:** You expect that other people will change to suit you if you just pressure or cajole them enough. You need to change people because your hopes for happiness seem to depend entirely on them.
13. **Global Labeling:** You generalize one or two qualities into a negative global judgment.
14. **Being Right:** You are continually on trial to prove that your opinions and actions are correct. Being wrong is unthinkable and you will go to any length to demonstrate your rightness.
15. **Heaven's Reward Fallacy:** You expect all your sacrifice and self-denial to pay off, as if there were someone keeping score. You feel bitter when the reward doesn't come.



Linda Nakell, Ph.D.

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# The Depression Workbook

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A Guide for Living With Depression  
and Manic Depression

MARY ELLEN COPELAND, M.S.

with contributions by  
MATTHEW MCKAY, Ph.D.

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**BDI**

# BECK Depression Eval.

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2 or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

- 1
  - 0 I do not feel sad.
  - 1 I feel sad.
  - 2 I am sad all the time and I can't snap out of it.
  - 3 I am so sad or unhappy that I can't stand it.
- 2
  - 0 I am not particularly discouraged about the future.
  - 1 I feel discouraged about the future.
  - 2 I feel I have nothing to look forward to.
  - 3 I feel that the future is hopeless and that things cannot improve.
- 3
  - 0 I do not feel like a failure.
  - 1 I feel I have failed more than the average person.
  - 2 As I look back on my life, all I can see is a lot of failures.
  - 3 I feel I am a complete failure as a person.
- 4
  - 0 I get as much satisfaction out of things as I used to.
  - 1 I don't enjoy things the way I used to.
  - 2 I don't get real satisfaction out of anything anymore.
  - 3 I am dissatisfied or bored with everything.
- 5
  - 0 I don't feel particularly guilty.
  - 1 I feel guilty a good part of the time.
  - 2 I feel quite guilty most of the time.
  - 3 I feel guilty all of the time.
- 6
  - 0 I don't feel I am being punished.
  - 1 I feel I may be punished.
  - 2 I expect to be punished.
  - 3 I feel I am being punished.
- 7
  - 0 I don't feel disappointed in myself.
  - 1 I am disappointed in myself.
  - 2 I am disgusted with myself.
  - 3 I hate myself.

- 8
  - 0 I don't feel I am any worse than anybody else.
  - 1 I am critical of myself for my weaknesses or mistakes.
  - 2 I blame myself all the time for my faults.
  - 3 I blame myself for everything bad that happens.
- 9
  - 0 I don't have any thoughts of killing myself.
  - 1 I have thoughts of killing myself, but I would not carry them out.
  - 2 I would like to kill myself.
  - 3 I would kill myself if I had the chance.
- 10
  - 0 I don't cry any more than usual.
  - 1 I cry more now than I used to.
  - 2 I cry all the time now.
  - 3 I used to be able to cry, but now I can't cry even though I want to.
- 11
  - 0 I am no more irritated now than I ever am.
  - 1 I get annoyed or irritated more easily than I used to.
  - 2 I feel irritated all the time now.
  - 3 I don't get irritated at all by the things that used to irritate me.
- 12
  - 0 I have not lost interest in other people.
  - 1 I am less interested in other people than I used to be.
  - 2 I have lost most of my interest in other people.
  - 3 I have lost all of my interest in other people.
- 13
  - 0 I make decisions about as well as I ever could.
  - 1 I put off making decisions more than I used to.
  - 2 I have greater difficulty in making decisions than before.
  - 3 I can't make decisions at all anymore.

Subtotal Page 1

CONTINUED ON BACK

- 14
- 0 I don't feel I look any worse than I used to.
  - 1 I am worried that I am looking old or unattractive.
  - 2 I feel that there are permanent changes in my appearance that make me look unattractive.
  - 3 I believe that I look ugly.

- 15
- 0 I can work about as well as before.
  - 1 It takes an extra effort to get started at doing something.
  - 2 I have to push myself very hard to do anything.
  - 3 I can't do any work at all.

- 16
- 0 I can sleep as well as usual.
  - 1 I don't sleep as well as I used to.
  - 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
  - 3 I wake up several hours earlier than I used to and cannot get back to sleep.

- 0 I don't get more tired than usual.
- 1 I get tired more easily than I used to.
- 2 I get tired from doing almost anything.
- 3 I am too tired to do anything.

- 18
- 0 My appetite is no worse than usual.
  - 1 My appetite is not as good as it used to be.
  - 2 My appetite is much worse now.
  - 3 I have no appetite at all anymore.

- 19
- 0 I haven't lost much weight, if any, lately.
  - 1 I have lost more than 5 pounds.
  - 2 I have lost more than 10 pounds.
  - 3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes \_\_\_\_\_ No \_\_\_\_\_

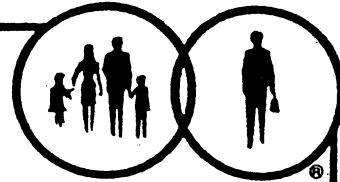
- 20
- 0 I am no more worried about my health than usual.
  - 1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
  - 2 I am very worried about physical problems and it's hard to think of much else.
  - 3 I am so worried about my physical problems that I cannot think about anything else.

- 21
- 0 I have not noticed any recent change in my interest in sex.
  - 1 I am less interested in sex than I used to be.
  - 2 I am much less interested in sex now.
  - 3 I have lost interest in sex completely.

\_\_\_\_\_ Subtotal Page 2

\_\_\_\_\_ Subtotal Page 1

Total Score



## Patient Information

### Counseling

Your family doctor may counsel you directly or may work with a mental health professional who does counseling. Counseling may help you get out of the rut of depressed thinking. It may also focus on things that might add to depression, such as an unhappy personal relationship, troubles in parenting, losses or other life problems.

### Self-Help

1. Set realistic goals for yourself and your progress. It may take time to get well. When faced with a task that seems too large, break it into smaller parts to do one at a time.
2. Reward yourself when you reach a goal.
3. Learn about depression. Ask your family doctor questions. Maybe your doctor can suggest some good books to read about depression.
4. Learn to look for situations and activities that make you feel better.
5. Keep a journal of your progress. Make notes about how you are feeling.
6. Think about how family problems, losses or other upsetting events may add to your depression.
7. Consider joining an educational or support group for depression. Your family doctor may be able to recommend groups in your area.
8. Exercise to keep yourself active.
9. Try not to keep yourself away from other people.
10. Be careful about using alcohol and other substances. Alcohol and sedatives can bring on depression or make it worse. Depression may also lead you to drink more coffee, smoke more cigarettes or take other drugs that can make you feel worse.
11. If you are having suicidal thoughts, discuss them with your doctor, family and friends, so plans can be made to keep you safe.
12. Be patient. Doing better and feeling better will take time and effort.

*This information provides a general overview on depression and may not apply in each individual case. Consult your physician to determine whether this information can be applied to your personal situation and to obtain additional information.*

## Assessment of Suicidality

Linda Nakell, Ph.D.  
Patty Hennigan, Ph.D.

### Questions to ask:

1. Do you think about hurting yourself?
2. Have you ever thought about suicide?
3. Have you thought about how you might harm or kill yourself?
4. Do you have access to weapons?
5. Do you have access to means of hurting yourself?
6. Do you intend to kill yourself?
7. Have you ever tried to harm yourself before? What happened?
8. What keeps you from acting on your thoughts of harming yourself?
9. What are your reasons to live?

### Risk factors for suicide:

1. Male sex
2. Age (under age 19 or over age 45)
3. Depression
4. Substance use
5. Availability of weapon
6. Previous suicide attempt
7. Loss of rational thinking
8. Lack of social support, isolation
9. Organized plan
10. Terminal or chronic illness
11. Time of year (April has highest suicide rate)

### No-suicide contract:

"Can you promise me that you will not harm or kill yourself intentionally or unintentionally before the next time we meet, and that you will call me or our Psych Emergency Services if you are in crisis?"